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A study of the social adjustment of twenty-eight children with epileptic seizures and predisposition to convulsions in the Louisville and Jefferson County Children's Home 1937-1948.

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A STUDY OF THE SOCIAL ADJUSTMENT OF TWENTY-EIGHT CHILDREN WITH EPILEPTIC SEIZURES AND PREDISPOSITION TO CONVULSIONS IN THE LOUISVILLE AND JEFFERSON COUNTY CHILDREN'S HOME 1937-1948

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NAME OF DEAN: Howell V. Williams

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INTRODUCTION TO THE RESEARCH

Purpose of the Study

This study is an attempt to understand the social adjustment of epileptic children and those with a predisposition to convulsions in the Louisville and Jefferson County Children's Home. The writer proposes to show what these children were like, why they were committed to the agency, what their problems were, and what kind of an adjustment they were able to make within the agency.

On July 1, 1947 the Inter-Agency Committee of the Health and Welfare Council of the Louisville Community Chest met to discuss the problem of the epileptic. This meeting was called at the request of one member, Mrs. Grace B. Caswell, Chief Social Worker of Nichols Veterans Administration Hospital. Mrs. Caswell stated that they were much concerned at Nichols about what was happening to the epileptics.[1]

The Inter-Agency Committee is a standing committee of the Health and Welfare Council of the Community Chest. It is one of the committees of the Family Welfare Committee

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[1] Minutes, Inter-Agency Committee, Health and Welfare Council, Louisville Community Chest, July 1, 1947, p. 1.

and is composed primarily or representatives of the case-working, or family and child welfare, agencies in Louisville and Jefferson County. The members of the committee were concerned about the problems of employment and vocational training for the older epileptic as well as the problems or the epileptic child; there was the problem also of securing information on the number or epileptics in Louisville and Jefferson County. In order to study possibilities and approaches to the problems of the epileptic, a sub-committee was appointed. It was composed of the following members: Mrs. Grace B. Caswell, Mr. David Dobson, Mrs. Catherine Richardson, and Mrs. Cora E. Lucas.[1]

The Sub-Committee of the Inter-Agency Committee met and planned a questionnaire which resulted in a summary or cases reported by twenty-five agencies as of July 1, 1947. These results were presented at the second meeting or the Inter-Agency Committee on September 4, 1947.[2]

Dr. James Rogers, who had been in charge or the Neurology Clinic at Louisville General Hospital from July, 1942 through July, 1946, was present at the September meeting of the Inter-Agency Committee. He discussed the medical treatment or epileptics and presented his own observations based on his work with patients who had attended Neurology Clinic at Louisville

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[1] Ibid., September 4, 1947, p. 1.

[2] See Appendix A, p. 82.

General Hospital during the period he supervised.[1] Dr. Ephraim Roseman, who succeeded Dr. Rogers as Head of the Neurology Clinic at Louisville General Hospital, was present at the meeting and gave further information on the subject of epileptics. He mentioned the two national organizations, American Epilepsy League, Inc., and the National Association to Control Epilepsy, which were doing a great deal to help the cause of the epileptic by distributing information and encouraging research.

It was pointed out that there was a need to educate the public as well as the epileptic. The social angles of the epileptic's problems were discussed. Dr. Ethel H. O'Brien, psychiatrist for the Jefferson County Juvenile Court and the Louisville and Jefferson County Children's Home, stressed the need for a special place for some children with epilepsy. She stated that there were a number of such children at Ormsby Village who did not fit in with the others in the institution. They did not have the type of personality suitable for institutions; they had a tremendous amount of irritability. There was discussion as to the desirability of placing such children in a special institution or mental sanatorium. The committee decided that the Sub-Committee would consider whether other phases of the problem should be studied.[2]

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[1] Minutes, September 4, 1947, p. 1.

[2] Ibid., pp. 2-3.

The Sub-Committee of the Inter-Agency Committee met on October 20, 1947 to discuss the proposed study of epileptics. Members present were Mrs. Louis Seelbach, presiding, Mrs. Irvin Abell, Jr., Mrs. Grace Caswell, Mrs. Cora Lucas, Dr. Ephraim Roseman, and Mrs. Louise R. Wood, secretary. At this meeting Dr. Roseman reported that Mr. Story Witten, State Supervisor of the Physical Restoration Service of the State Vocational Rehabilitation Department, might start a special program for epileptics which would include a clinic and vocational training. The social service history of each case would be studied. Dr. Roseman stated that the first problem of the epileptic was medical care and the second was social adjustment, including employment. He further stated that one of the most important needs to be met was educating the schools to keep epileptic children in school. As to the work of the Committee, he stated that he thought the first job was publicity and education but he advised waiting for the proposed clinic to open to present an opportunity for extensive publicity. Mrs. Caswell reported that some of the students from the Kent School of Social Work, University of Louisville, might be interested in a study of Jefferson County. She had spoken to Miss Mathilda Mathisen, faculty member of the Kent School, about the Committee's interest. Miss Mathisen was supervising four medical social work students, each of whom might be interested in the study as a thesis, if each could take a separate part of the problem of epilepsy.[1]

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[1] Minutes, Sub-Committee of Inter-Agency Committee, October 20, 1947.

It was as a result of the foregoing committee activities and interests that the decision was reached and plans were made with the Kent School to permit the four Kent School medical social work students to make separate studies as theses in partial fulfillment toward the requirements for the degree of Master of Science in Social Work. The areas decided upon were: the child in the community, the child in the institution, the veteran, and vocational rehabilitation. This study has to do with the second named field, the child in the institution.

Scope and Method of the Study

The original scope of this study was to include children up to and including sixteen who had convulsions or seizures and who were living in institutions in Louisville or Jefferson County. As noted in the results from the Inter-Agency Committee Questionnaire on Epileptics as of July 1, 1947,[1] Louisville and Jefferson County Children's Home reported 15 cases and St. Vincent Orphanage reported 2 cases. Although the writer rather expected to find the majority of cases at the Louisville and Jefferson County Children's Home, she did expect to locate additional cases at other institutions over a period of five or ten years. With this approach in mind, all children's institutions as listed in the Directory of Social

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[1] See Appendix A, p. 82.

Agencies for Louisville and Jefferson County, of the Health and Welfare Council of the Louisville Community Chest, plus Central State Hospital, Lakeland, Kentucky, were approached.[1]

In this survey of sixteen institutions the findings were surprisingly meager. One case was reported by St. Joseph's Orphanage, and 2 cases were reported by St. Vincent's Orphanage. A preliminary survey showed 13 cases at the Louisville and Jefferson County Children's Home with a possibility of more upon further investigation. One of the interesting features of this original survey was the fact that nearly all of those institutions who reported no cases at all were of the opinion that they had never had an epileptic child in their institution, One of the Catholic Sisters contacted stated that she had never encountered a Negro epileptic child in all the many years she had worked with children. In making this survey the person usually approached was the Superintendent, someone in charge of the children, or someone who had been connected with the institution for a period of time long enough to be familiar with the situation. In several cases it was noted that the institutions stressed their rigid physical examination upon entrance, and they stated that no epileptic child would have been accepted. Central State Hospital reported no cases of children from Jefferson County at the time of inquiry. Due to their method of filing only active cases by diagnosis they were unable to make accessible the records of former, inactive cases.

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[1] See Appendix B, p. 83.

The 1 case reported by St. Joseph's Orphanage proved to be a child later committed to Louisville and Jefferson County Children's Home and included in their count. When it became apparent that only 2 cases had been located that were unknown to Louisville and Jefferson County Children's Home, the writer felt justified in altering the original scope of the study from children living in institutions in Louisville and Jefferson County to one agency, namely, the Louisville and Jefferson County Children's Home. In this way, the study could be expanded to include the entire period of commitment to the Louisville and Jefferson County Children's Home, instead of merely the time when the child was living in the institution proper. Since the program of the Louisville and Jefferson County Children's Home includes much beyond the actual institutional life at Ormsby Village and Ridgewood, it was felt that the study would be of greater value with the change of focus. Many of the wards of the Louisville and Jefferson County Children's Home are placed in boarding or foster homes, and many are placed in their own home or with relatives. As the ultimate goal of the institution is to return the child to the community and society, and to his own home if that is possible, this study of epileptic children in the Louisville and Jefferson County Children's Home is an attempt to show how these children responded to their total period of commitment, that is, how they adjusted to their various placements in the community and in the institution.

Because it was believed that for most children with epilepsy the crippling effect is social and not physical, this study was concerned with the social adjustment of children with epileptic seizures and predisposition to convulsions in the Louisville and Jefferson County Children's Home. The study includes 28 cases over an eleven year period from March, 1937 through April, 1948. The method used was both the statistical approach and the case study method.

The primary source of information was the case record of each child. Each case record contained three separate sections: (1) reports, including medical, psychological, psychiatric, school, and conduct reports; (2) correspondence section, including letters or correspondence, notes, inter-office memos, council and conference notes, change of status reports, commitment and release papers, and other miscellaneous items; and (3) social service record, including the social worker's "running record" and also the court summary, recommendations to the Board, placement and transfer summaries, and Board reports. As previously stated, the primary source of information was from these records. In several instances, where the social service record was not up to date, the writer discussed the case with the social worker to fill in the gap.

As to case finding, the agency had compiled a list of epileptic children in July, 1947 in response to the Questionnaire

sent out by the Inter-Agency Committee.[1] This list was available as a starting point. The agency did not maintain a record by medical diagnosis of the children committed. Therefore, it was necessary to depend upon the memory of the various workers for locating the cases to be studied. Another aid to case finding was referral to a medication list maintained by the agency. These lists were available for the period February 8, 1944 through March 18, 1948, with some gaps throughout. Dr. Ethel H. O'Brien, psychiatrist for the Juvenile Court and the Louisville and Jefferson County Children's Home, was able to suggest the names of several children who showed a predisposition to epilepsy. Inasmuch as the original 13 cases as reported by the agency in July, 1947 included children with a predisposition to epilepsy, these were made a part of the present study. Had time permitted, the writer would have included additional children with a predisposition to convulsions, for it is felt that their number has not been exhausted.

In order to better understand the group of children in this study and to see what sort of an adjustment they were able to make during their commitment to the Louisville and Jefferson County Children's Home, a schedule[2] was prepared. The following various types of information were secured: sex, race, age when committed, diagnosis, reason for commitment, age at onset of

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[1] Supra, p. 3.

[2] See Appendix C, pp. 84-86.

seizures or behavior problems, frequency of attacks, attitudes of the child and his family toward epilepsy, types of behavior the child exhibited before commitment and how handled, siblings, history of seizures in the family, how the child adjusted in the institution, medication, control of seizures, mental development, school achievement and placement, psychiatric referrals, disposition upon release, and reason for release.

These data were treated statistically and appear in tables to show various phases in the child's social adjustment. The case study method was used to illustrate material which did not lend itself to statistical analysis. The findings of this study are presented in Chapters III and IV.

The Louisville and Jefferson County Children's Home

Thorough studies of the Louisville and Jefferson County Children's Home have been made by such organizations as the Child Welfare League of America, the Russell Sage Foundation, and the Osborne Association. The changes in philosophy of child care in relation to specific problems which are common to all institutions that have to deal with delinquent and dependent children have been traced in a previous study by Sherrill.[1] The present study is not intended in any way to

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[1] Helen H. Sherrill, "Changing Philosophy of Child Care in the Louisville and Jefferson County Children's Home (1854-1943)," Unpublished Master's Thesis, Graduate Division of Social Administration, University of Louisville, 1944.

duplicate those works. A few facts about the Louisville and Jefferson County Children's Home, however, may be helpful in understanding the child in his environment.

Something of the growth of the institution may be seen from the changes in its name. It dates back to Civil War times when it was created as "The Louisville House of Refuge." About twenty years later the name was changed to "The Louisville Industrial School or Reform." In 1920, when it was consolidated with the Jefferson County Parental Home, it became "The Louisville and Jefferson County Children's Home." This name still designates the agency as a whole, but the more informal names "Ormsby Village" and "Ridgewood" are used respectively for the two institutional divisions for the white and negro children.

The Louisville and Jefferson County Children's Home is a public agency supported jointly by the city of Louisville and Jefferson County. All children under care have been committed through the Jefferson County Juvenile Court.[1] In accordance with the change in thinking as to the best type of care for delinquent and dependent children, there has been an increasing tendency to place children in foster homes, or wherever possible to keep them in their own homes.[2]

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[1] Margaretta Weber, Working with Dependent and Delinquent Children in the Same Institution (Anchorage, Kentucky: Ormsby Village Press, 1935), p. 1.

[2] Sherrill, op. cit., p. 31.

Besides the two institutions, Ormsby Village and Ridgewood, the Louisville and Jefferson County Children's Home also has charge of the Children's Center, formerly called the Detention Home, and Sunshine Lodge which is an adjunct of the Children's Center. Here are received for temporary care, pending final disposition by the Juvenile Court, the dependent, neglected, and delinquent children of Jefferson County. The Center is used for the older children, and Sunshine Lodge is used for the younger children, below the age of ten.[1] However, all children are first cleared through the Center. The function of the Children's Center is best described as a threefold one. (1) It is a detention home for all juveniles of Jefferson County awaiting hearing by the Juvenile Court. Some may be committed to the Louisville and Jefferson County Children's Home and some may not be; some may already be wards of the agency. (2) It is a receiving home for all children committed by the Juvenile Court to the Louisville and Jefferson County Children's Home. These children remain in the Children's Center until plans are formulated for them as to their placement, either at the institution, Ormsby Village or Ridgewood, in a foster home, in their own home, or with

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[1] Personal interview with Mr. William H. Pyne, Assistant Superintendent, Louisville and Jefferson County Children's Home and Supervisor of the Children's Center, May, 1948.

relatives. (3) It is a temporary abode for Louisville and Jefferson County Children's Home wards between transfers and placements, while receiving special care, study or treatment such as medical, psychological, psychiatric, and case work service, or for any other special reason which the agency might feel was needed for the child.

The Social Service Department is a vital part of the Louisville and Jefferson County Children's Home. It has contact with the child as soon as he is committed by the Juvenile Court to the Louisville and Jefferson County Children's Home. Until approximately two years ago, a member of the Social Service Department participated in scheduled conferences at the Juvenile Court where the decision was made as to whether or not the child should be recommended for commitment. This practice has been discontinued on a routine basis, however, and conferences are now made only by appointment. It is the hope of the agency that these regularly scheduled conferences will be resumed.[1]

As soon as a child is committed to the agency, a social worker is assigned to him. This contact is begun while he is still at the Children's Center and continues during his entire period of commitment, or until the agency releases him. Case work service is given to every ward of the Louisville and

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[1] Personal interview with Mrs. Catherine Y. Fox, Assistant Director and Supervisor of Case Work, Louisville and Jefferson County Children's Home, May, 1948.

Jefferson County Children's Home. The initial study of the child is begun while he is still at the Center. He is given a physical examination and tested by the Psychology Department. Where indicated, psychiatric service is available. The social worker has the use of these reports with possible recommendations, which help in formulating plans for the child. His problems are considered from every angle in the hope of effecting the kind of placement which will be most helpful and desirable for him. His interests and abilities are discovered, and he is given some interpretation of the institution if that is to be his placement. Relationship with the child by the social worker is maintained throughout his entire commitment.

The most impressive thing observed by Mrs. Sherrill in her study was the manner in which each child was considered as an individual from the time of commitment until his release.[1]

Ormsby Village and Ridgewood are built on the cottage plan. The open system without confining walls is a feature of the "campus," as the children generally speak of the Village. There is no segregation of dependents and delinquents.

The psychiatrist for the Juvenile Court, Dr. Ethel H. O'Brien, is also the psychiatrist for the Louisville and Jefferson County Children's Home. Thus she is active on many cases and familiar with some of their problems before they are actually committed to the Home.

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[1] Sherrill, op. cit., p. 18.

CHAPTER II

SOME FACTS ABOUT EPILEPSY

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This chapter will attempt to set forth briefly some of the facts about epilepsy. First, what is epilepsy?

> In the last two decades, older concepts of the nature and origin of these paroxysms have crumbled under the discoveries and contributions of neuro-pathologists, neurosurgeons, biochemists, physiologists, and physicians, who now consider these seizures to be not a disease, but a symptom of underlying pathology. Convulsive seizures are so infinitely variable in character and incidence and generally so hidden in origin that they have deried attempts at definition. Because of this, the name "epilepsy" is considered by many authorities to be an inaccurate and undesirable term. It has been suggested that "paroxysmal disorders," "convulsive state," or "convulsive seizures," be used instead.[1]

Lennox, who is considered by many to be one of the foremost authorities on epilepsy, believes the word "epilepsy" should not be opposed but that the public should be educated to a sane and scientific attitude toward it. He suggests the use of the word "seizures," which is synonymous with "epilepsy" or "fits." Another descriptive term is "cerebral (brain) dysrhythmia (disordered rhythm)."[2]

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[1] The Epileptic Child in Illinois (Illinois Commission for Handicapped Children, June 1943), p. 9.

[2] William G. Lennox, Science and Seizures (2d Edition; New York: Harper and Brothers, 1946), pp. 18-19.

The three kinds of seizures are described by Yahraes[1] in the following words:

1. Grand Mal

This "great illness" affects more persons than other types of epileptic seizures. During a grand mal attack, the patient loses consciousness, his muscles tighten, and he falls. He may cry out or groan, although he does not remember pain. Saliva appears on his lips. His face may be first dusky and then pale. He twitches violently for a minute or two--it seems much longer to the worried bystander. Usually in a few minutes he lies relaxed. Then he may sleep heavily for hours, or he may get up but feel dull for a short period.

2. Petit Mal (pykno-epilepsy)

Seizures are much more frequent in this "small illness" but are often overlooked because they last only a few seconds. Usually there is a rhythmic twitching of eyelids or eyebrows. The patient rarely falls.

Dr. Tracy Putnam gives this account of petit mal attack: "The patient was sitting calmly in the office, discussing his symptoms. He stopped in the middle of a sentence, stared vacantly, blinked, and went on with what he was saying, only slightly confused." Parents often disregard petit mal attacks in a child, supposing that eventually they will disappear. Usually they do. However, out of a large group studied, one out of every three patients with petit mal later develop grand mal.

3. Psychomotor

This is the most difficult to diagnose because the attacks vary greatly from one patient to another and because mild forms may look like petit mal and severe forms like grand mal. The name indicates that a psychic disturbance is the principal feature of the attacks. This type is infrequently found.

In a psychomotor seizure the patient is amnesic; that is, he may appear to be conscious, although afterward he does not remember anything that happened. Most such attacks last only a few minutes but with a few patients they continue longer. Patients have even gone

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[1] Herbert Yahraes, Epilepsy--The Ghost is Out of the Closet, Public Affairs Pamphlet No. 98 (New York: Public Affairs Committee, Inc., 1944), pp. 18-20.

> to a strange city without knowing what they were doing. The psychomotor seizure may appear to be only a temper tantrum or a period of queer behavior--as in the case of a man who would wander around the room pulling down pictures and throwing books on the floor. When such episodes begin abruptly, are contrary to the person's ordinary character, and are not remembered by the patient, they are suggestive of epilepsy. In many cases it is hard for parents and associates to believe that the patient's behavior is caused by anything but a "mean streak," But evidence that it is caused by a form of epilepsy can be shown by the electroencephalograph, or by the alleviation of such attacks following medical treatment.

All types of seizures may be so mild as to be hardly discernible. A psychic or psychomotor seizure may manifest itself as a period of sharply altered disposition, or of an aggressive, antisocial act which the person cannot account for. Some "behavior problem" children are of this type. The borderline between psychic seizures and other disorders of mind or conduct is not sharply drawn. The presence also of petit mal or grand mal attacks and the distinctive electrical record of the brain classifies the acts as epileptic.[1]

As to causes, Dr. Lennox states that in about one-fourth of the cases some injury to the brain is at fault--injury resulting from a severe blow, encephalitis, meningitis, a tumor, or hardening of the brain arteries. The more usual cause is an inherent tendency or predisposition to seizures which was present at birth. Seizures may also result from

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[1] Lennox, Science and Seizures, pp. 31-32.

disorders of body function such as the great lowering of the blood sugar, or some unpleasant or terrifying experiences may bring an underlying tendency to the fore.[1]

An aid in diagnosis and treatment is the electroencephalograph, an instrument for recording the electrical currents or waves of the brain. The electroencephalogram (electric brain record) is commonly called E.E.G. or "brain waves." The electroencephalogram helps in differentiating epilepsy from fainting or hysteria, in locating brain injuries or tumors, in indicating the seriousness of the case, in suggesting the best drug to be used, and in following the success of the treatment.[2]

The three most commonly used drugs at the present time are dilantin, used for grand mal and psychomotor seizures; phenobarbital, also used for grand mal and psychomotor epilepsy; and tridione, used for petit mal epilepsy. The last named drug cures completely approximately 30 per cent of petit mal cases, helps 30 per cent, and is of no value at all to another 30 per cent. Tridione is a convulsant, and if the patient has a combination of grand mal and petit mal it will cause convulsions of the grand mal type. Therefore, it is necessary first to control the grand

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[1] Lennox, The Epileptic--Who He Is--What He Can Do (Chicago: American Epilepsy League, Inc., undated), p. 2.

[2] Ibid., p. 3.

mal seizures (by dilantin or phenobarbital) and then to use the tridione for the petit mal.[1]

No general census of the number or persons having seizures is available either for the United States or any other country. Due to the nature or the problem, it does not lend itself readily to statistical study. It is often concealed for fear of social stigma. Many suffering from the disorder do not seek medical treatment, believing it to be incurable. Or, the seizures may be so mild that they are not recognized for what they are. For these reasons, most estimates made as to the incidence of seizures are too low.[2]

Nevertheless, Dr. Lennox estimates that there are at least 500,000 persons in the United States who are or have been subject to seizures. This is about equal to the number having active tuberculosis or diabetes. It is, therefore, a very important disorder. And when one considers that for every person who has seizures, there are about twenty who have a predisposition to it, its importance is multiplied.[3] Dr. Roseman, of Louisville General Hospital, estimates that Kentucky has 30,000 epileptics, of whom 20,000 are below the age or sixteen.[4]

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[1] Lecture by Dr. Ephraim Roseman to a class of the Kent School or Social Work, University or Louisville, April 20, 1948.

[2] The Epileptic Child in Illinois, p. 16.

[3] Lennox, Science and Seizures, p. 21.

[4] Lecture by Dr. Roseman, April 20, 1948.

Dr. Lennox states that peculiarities of personality or behavior are almost the rule among institutional epileptics, while they are the exception among clinic or private patients. There may be a "Dr. Jekyll and Mr. Hyde" type of personality, cheerful and cooperative one day, the next day antagonistic, resistive, irritable, or moody. In other patients, however, there are constant and apparently fixed characteristics of stubbornness, loquacity, persistent "one track" ideas, petty bodily symptoms, and complaints. Some call this the "epileptic personality." Dr. Lennox believes that these unpleasant traits are found but rarely in intelligent patients who have received proper psychological treatment from the beginning. He believes these traits of instability and hypochondriasis are not limited to epileptics but are symptoms found in any chronic illness.[1]

To correct some of the common fallacies about epilepsy, these counter statements are suggested by Lennox:[2]

> The tendency is for seizures to get better with the years rather than worse. Mental deterioration is not a necessary or even usual accompaniment of epilepsy. It is better to have "true" epilepsy rather than so-called "symptomatic" epilepsy. Activity of body and mind and not "complete rest" is the best treatment for most patients. The great majority of patients, perhaps 75 per cent, can be rid of three-fourths of their seizures and many are completely well with careful following of experienced medical advice. Epilepsy is not a complete mystery. The cause is as well known as the cause of diabetes or obesity. Finally, continued research should uncover new methods of treatment.

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[1] Lennox, The Epileptic Patient and the Nurse (Boston: American Epilepsy League, Inc., undated), pp. 12-13.

[2] Ibid.

CHAPTER III

CHARACTERISTICS OF THE GROUP

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Sex, Race, and Age at Commitment

Twenty-eight cases were studied. As shown in Table 1, the children ranged in age from 6 to 16 years at the time of their commitment. There was a fairly even distribution in age, with the largest number of commitments (8) at the age of 13. Four children each were committed at the ages of 14 and 6 years. The remaining 12 children were distributed throughout the other years in smaller numbers. It is interesting to note that the majority of children were committed during adolescence.

TABLE 1

AGE OF COMMITMENT BY SEX AND RACE

Age at Commitment	Sex						
	Male			Female			
	White	Negro	Total	White	Negro	Total	Total
6	2	-	2	2	-	2	4
7	1	-	1	-	-	-	1
8	-	-	-	-	-	-	-
9	3	-	3	-	-	-	3
10	1	1	2	-	-	-	2
11	2	-	2	-	-	-	2
12	-	-	-	-	1	1	1
13	5	2	7	1	-	1	8
14	3	1	4	-	-	-	4
15	1	-	1	1	-	1	2
16	-	1	1	-	-	-	1
Total	18	5	23	4	1	5	28

By sex, there was an unequal distribution. Twenty-three or the 28 children were males. Of the males, there were more than three times as many white boys (18) as negro boys (5) in the group. Of the 5 girls included in the study, 4 were white and 1 was negro. These findings are interesting but hardly significant, in view or the small number of cases studied. They do not seem to go along with the statement that "incidence of seizures is about the same in the two sexes."[1] It is very likely that the distribution would have become more balanced as the number increased, but that is only a conjecture.

Mental Development and School

Table 2 shows the distribution in percentage of children by level of intelligence. This is compared with the level or intelligence or a group or children committed to the Louisville and Jefferson County Children's Home over a year's period or time and with the general population.

The classifications used ror level or intelligence are those used by the Psychology Department or the Louisville and Jefferson County Children's Home. I.Q. scores corresponding to these classifications are as rollows: very superior, 140 and above; superior, 120 - 139; bright normal, 110 - 119; average, 90 - 109; dull normal, 80 - 89; borderline, 70 - 79; mental defective, below 70.

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[1] Lennox, Science and Seizures, p. 39.

TABLE 2

LEVEL OF INTELLIGENCE IN LOUISVILLE AND JEFFERSON COUNTY CHILDREN'S HOME POPULATION, GENERAL POPULATION, AND STUDY GROUP

Level of Intelligence (1)	Per Cent General Population[a] (2)	Per Cent L&JCCH Commitments[b] (3)	Per Cent Study Group (4)
Very Superior	0.25	-	-
Superior	6.75	1.30	3.60
Bright Normal	13.00	5.50	-
Average	60.00	31.10	35.70
Dull Normal	13.00	25.30	32.20
Borderline	6.00	25.30	21.40
Mental Defective	1.00	11.50	7.10

[a] Figures from Florence M. Teagarden, Child Psychology for Professional Workers (rev. ed.; New York: Prentice-Hall, Inc., 1946), p. 393.

[b] Figures compiled from computations taken from Pauline Klinger, Second Annual Report, Psychology Department, L&JCCH, Anchorage, Kentucky, July 1, 1944-July 1, 1945. Pages unnumbered.

The figures in column 3 were compiled by the writer from computations secured on all new commitments to Louisville and Jefferson County Children's Home for the year July 1, 1944 to July 1, 1945. The percentages used in the report were derived from verbal I.Q. scores. The figures in column 2,

pertaining to the general population, were taken from Teagarden's Child Psychology for Professional Workers. Miss Teagarden stated that the figures were approximations derived from many sources and were fairly familiar and in common use.[1]

The percentages for the 28 children studied by the writer appear in column 4. Again, due to the small number of cases studied, it is not felt that any generalizations can be made, but it is interesting to see where these 28 children group themselves.

It can be seen that by far the largest percentage of the general population (column 2) falls in the average category and that the percentages of the general population included in other categories become smaller and smaller as one moves away from the average toward the extremes of the distribution. The Louisville and Jefferson County Children's Home commitment group, on the other hand, falls more largely into the dull normal, borderline, and mental defective ranges than does the general population, with few in the average, bright normal, and superior categories. To quote Miss Elizabeth McCarley, Head of the Psychology Department, Louisville and Jefferson County Children's Home, "Our reports, in reference to children's levels of intelligence, more often contain the terms dull normal and borderline than the terms

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[1] Florence Teagarden, Child Psychology for Professional Workers (rev. ed.; New York: Prentice-Hall, Inc., 1946) p. 391.

superior and bright normal."[1] In this connection, then, it can be seen that the 28 children included in this study align themselves within the categories one might expect to be more popular in the Louisville and Jefferson County Children's Home.

Table 3 shows two relationships: (1) the relationship between level of intelligence and educational achievement as portrayed by the results of psychological testing, and (2) the relationship between the child's actual school grade placement and his educational achievement.

The verbal scores of the intelligence test were used as the basis for categorizing the child as average, dull normal, etc. His educational achievement was secured from the results of an achievement test. In most cases the Educational Quotient and the grade score were given, which showed the level at which the child had tested to perform in school work. When his performance was on a par with his level of intelligence, the writer interpreted and tabulated this as standard (column 3); when his performance was below his native ability, he was considered as below (column 4); when no achievement test was administered, the writer used the unknown column (5).

It was felt that it was more fair to make a comparison between the child's grade placement and his achievement than between his placement and his level of intelligence, but all

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[1] Memorandum written by Elizabeth McCarley, Psychology Department, L&JCCH, "Classification of Intelligence According to Test Performances," December 12, 1947.

TABLE 3

RELATIONSHIP OF EDUCATIONAL ACHIEVEMENT BY LEVEL OF INTELLIGENCE AND GRADE PLACEMENT BY LEVEL OF INTELLIGENCE AND EDUCATIONAL ACHIEVEMENT

Level of Intelligence (1)	Achievement and Placement									
		Educational Achievement			Grade Placement by Educational Achievement					
	Total (2)	Standard (3)	Below (4)	Un-known (5)	Standard (6)	Below (7)	Above (8)	Special (9)	Un-known (10)	Non-attendance (11)
Very Superior	-	-	-	-	-	-	-	-	-	-
Superior	1	-	-	1	-	-	-	-	1	-
Bright Normal	-	-	-	-	-	-	-	-	-	-
Average	10	3	6	1	3	1	4	-	1	1
Dull Normal	9	1	6	2	1	-	3	3	1	1
Borderline	6	2	-	4	-	-	1	1	2	2
Mental Defective	2	1	-	1	-	-	1	1	-	-
Total	28	7	12	9	4	1	9	5	5	4

the time taking into account his level of intelligence. Therefore, the second part of the table, columns 6 through 11, is interpreted in this way. For example, when a child of average ability (level of intelligence) made a grade score or educational achievement compatible with this level and was also actually placed in a grade at the same level, he was considered standard, column 6; if he had been placed in a grade below his achievement, he would have been considered below, column 7. Some children were placed in a special and ungraded classes and this accounts for column 9. Naturally, if a child had not been given an achievement test, his grade placement, no matter what the grade, high or low, could not be compared with an unknown achievement. The other columns are self-explanatory.

With this interpretation in mind, the table reveals some interesting facts. It appears that nearly one-half (12) of the children upon commitment to the Home did not achieve at their level of intelligence. These were children not at the lowest extreme, for they were average and dull normal. Seven of the 28 children showed achievement comparable with their native level; the remaining 9 either were not given achievement tests or the results of the test were not available.

As to actual grade placement, 4 of the children were placed in a grade compatible with their level of achievement;

3 of these were of average, 1 of dull normal ability. One child, of average ability, was placed below his performance as shown in achievement test. The largest number of children, 9, were placed in a higher grade than shown on the achievement test; 4 of these were of average ability, 3 of dull normal, and 1 each in the next two lower categories. These 9 children, it would seem, might encounter some difficulty by the higher placement. It is noted that 5 children were placed in special classes, where the needs of the individual child were considered. This method was often used at the institution, as well as in some of the city public schools. Adjusting the curriculum to fit the special needs of the child where he would find the regular graded classwork too competitive and too difficult is a device used in many school systems today.

There are many reasons why children do not attend school. It was interesting to see some of the most common reasons for missing school among this group of children. Table 4 gives a picture of this. By showing the results in relation to level of intelligence, the figures are more maningful.

Examination of Table 4 shows the significant fact that unauthorized absences and lock-up or detention in the Children's Center were the main reasons for non-attendance

TABLE 4

REASONS FOR SCHOOL NON-ATTENDANCE ANY TIME
BY LEVEL OF INTELLIGENCE

Reason for School Non-Attendance*	Level of Intelligence							
	V Sup	Sup	Br N	Aver	Dull N	Border	Ment Defec	Total
Total Children	-	1	-	10	9	6	2	28
Lock-up or Children's Center	-	1	-	8	7	4	2	22
Unauthorized Absence	-	1	-	8	7	4	2	22
Mental Deficiency	-	-	-	-	2	1	-	3
Home Conditions	-	-	-	1	1	-	-	2
Hospitalization	-	-	-	6	2	2	1	11
Seizures	-	-	-	3	3	1	-	7
Expelled due to Behavior Problems	-	-	-	2	2	1	-	5
Health Exclusive of Seizures	-	-	-	-	1	-	-	1
School Non-Acceptance due to Court Record	-	-	-	1	-	-	-	1
Used Spells to be Excused	-	-	-	2	-	-	-	2

*The data shown in vertical columns are duplicated as non-attendance by one child may have been caused by more than one factor.

V Sup - Very Superior
Sup - Superior
Br N - Bright Normal
Aver - Average
Dull N - Dull Normal
Border - Borderline
Ment Defec - Mental Defective

at school by these 28 children. Twenty-two of the 28 children missed school due to these two reasons. The distribution was fairly even among each level of intelligence.

There were 3 children who missed school due to mental deficiency. Two of these were dull normal and 1 was borderline. The case of Jasper is used as an illustration.

> Jasper, age 11, dull normal, was a thin, sallow faced boy who was often described as an unhappy and "pathetic" child. He had been in the second grade before commitment. Plans had been made to place him in a foster home with two younger siblings, but due to his history he was brought to Ormsby Village for study from neurological, psychiatric, and psychological angles. He remained on campus for eight months where he felt "picked on" by the other children. His small physique and social inferiority made it difficult for him to defend himself in the group. As a result of his inadequacies and irritating manner he was constantly "picked on."
>
> His teachers at the Village felt he needed to be where he could feel more secure and receive much personal attention. They did not believe institutional life was best for this child. Jasper also was an enuresis problem and an excessive smoker, the latter since the age of four. He had epileptic seizures and was on medication. Some of his behavior was "queer" and "crazy acting," as if he had no reasoning power. All his family considered him feebleminded. He cried incessantly, and his teachers thought he had gone "down hill" and needed the individual attention a foster home could provide. He lacked motor control enough to write and was unable to do second grade work.
>
> His first foster home placement, after eight months at Ormsby Village, lasted one and one-half months. Jasper went to it "thrilled" over the prospect and with the offer to give up smoking. After a week the foster mother discontinued his medication without consulting the agency, for she thought it made him too "dopey."
>
> Jasper was placed in second grade at the public school. The school was given a psychological report and a history of his problems and needs. His childish mannerisms, nervousness, stealing, and inability to learn made his school supervision very difficult. The school principal

> and teacher refused to allow him in school and threatened to send him to Feeble Minded Institute. His foster mother stood by him until the stealing episode, with which she felt unable to cope. She thought him sweet and obedient in the home, though slow and exasperating. She said he was a clever, adaptable child.

Two children did not attend school due to home conditions. These both occurred during placements in their own homes. Charles is cited as an example.

> Charles, a boy of average ability, was committed at 14 as a dependent, in that there was no proper guardianship, no visible means of subsistence and the home was unfit. The father had deserted and five younger siblings were all placed in Catholic orphanages.
>
> Charles "marked time" at Ormsby Village. At first he blamed his mother for his commitment and never wanted to see her. Soon he began a series of unauthorized absences during which he always went home, his mother reporting him shortly thereafter. After a stay of two months in Children's Center during which he received psychiatric service pending plans, he was placed at home with his mother and enrolled in parochial school. This was recognized as a poor situation due to the mother's rejection of Charles and his consequent resentment of her drinking and immorality. After a stormy two weeks Charles was willingly returned to the Children's Center. His attendance at school had been erratic. School authorities and neighbors stated that Charles behaved well and thought the mother was the basis of the trouble in their constant quarreling and fighting.

Eleven of the 28 children missed school due to hospitalization other than that pertaining to their seizures. Seven children did not attend school because of their seizures. Three of these were of average ability, 3 were dull normal, and 1 was borderline. Douglas, the boy of borderline ability is used as illustration.

Douglas began to have grand mal seizures at the age of 11, two years after his commitment and while he was at Ormsby Village. Immediately following commitment he was placed in his first and only foster home where he remained for ten months. He made a satisfactory adjustment, was sociable and made friends quickly. He was returned to Ormsby Village because the foster mother secured full time employment.

Douglas then stayed at Ormsby Village for four years. It was during this time that his epileptic seizures began. He was a small boy and used that as an excuse to get out of work. He was very babiried, cried frequently and capitalized on his size. His conduct was fair, with occasional temper tantrums. As his attacks diminished he became more nervous. His cottage mother described him as "absolutely truthful, never impudent, and the best child on campus." He was finally placed at home with his elderly grandmother and half-sister who was feeble minded. The mother, an epileptic, was dead, and the father had deserted. Douglas had been in an ungraded class at the Village, and he was given a similar placement in the city school, where he adjusted well and was happy. He remained in school in such an assignment for two years. The teachers and children were fond or him.

Then he began having seizures again. He was so embarrassed when they happened at school that he was allowed to withdraw from school. The school felt he had made no progress whatever in his work. He was 16 years old at the time. At the death or the grandmother, there were no relatives willing or financially able to take responsibility for Douglas.

During his placement with his grandmother it was felt that he had deteriorated mentally. He was socially inadequate, wandering about on his bicycle until very late at night. He could not keep himself clean or properly clothed. He was in no way equipped to support himself. In his own words he could do nothing but "ride a bike." Douglas had, however, shown some aptitude with his hands. In view or all this, he was filed on for admission to Kentucky Training School (formerly Feeble Minded Institute). To substantiate this a later psychological test was given. In this he tested at the lowest point in the borderline group. One point lower on the test would have placed him at the high moron level. Douglas was accepted by and entered Kentucky Training School.

There were 5 children who were expelled because of behavior problems. It is interesting to note that 2 were of average and 2 of dull normal ability.

One boy was placed in a private, religious boarding school by his mother soon after his commitment to the agency. He had average ability and offered no problems except for the complaint that he would not study. His stay there was short-lived. When the school learned he had a Juvenile Court record they refused to keep him.

Two children, of average ability, "used" their spells to get excused from school. One boy did not want to take Physical Education while placed at home. He arranged for an excuse from a private physician even though the agency physician would not recommend his exemption from the class.

Reason for Commitment

The statutes of the Louisville and Jefferson County Children's Home provide for the care of dependent, neglected, and delinquent children. However, the Jefferson County Juvenile Court commits children on only either of two bases, dependency or delinquency. It has been stated that by far the largest number of the children committed to the agency were neglected.[1] Table 5 shows the reason for commitment according to sex and race.

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[1] Personal interview with Mrs. Catherine Y. Fox, May, 1948.

TABLE 5

REASON FOR COMMITMENT BY SEX AND RACE

Reason for Commitment	Male			Female			Total
	White	Negro	Total	White	Negro	Total	
Dependency	10[b]	3[a]	13	3	1	4	17
Delinquency	8[a][c]	2	10	1	-	1	11
Total	18	5	23	4	1	5	28

[a]One child was committed a second time as a delinquent.

[b]One child was committed a second time as a dependent.

[c]One child was committed a second and third time as a delinquent.

The majority of the children were committed on dependency rather than delinquency charges. This would seem to bear out the above statement that many children were neglected. Some children brought in to court on delinquent charges in the petition are frequently committed as dependents. This might seem to be due to the fact that upon court investigation the child was seen to be more neglected than delinquent, thus causing the court to change the charges from delinquency to dependency. The writer has no facts to substantiate this observation. Of the 23 boys in the group, the basis for commitment was fairly evenly divided--13 on dependency and 10 on delinquency. The girls showed a less balanced picture. Five girls were committed; of these, 4 were for dependency and 1 for delinquency.

The fact that 4 children had recommitments is not as significant as one might first believe. One boy had three commitments, each upon the basis or delinquency. This was really a matter of technicality by the Juvenile Court for there was no break oetween the dates of release and recommitment. During the time of this boy's commitment, the Juvenile Court judge instituted the practice of the agency releasing any ward of the Louisville and Jefferson County Children's Home who was to appear in court on charges. Therefore, this boy was released by the agency, only to be recommitted to the agency immediately thereafter.

With the other 3 children, there was a lapse or time between release by the agency and recommitment by the Juvenile Court. The case of Stephen, who had two commitments for delinquency is cited. He ran away when returning from Louisville General Hospital to the Children's Center after receiving an electroencephalogram. This was three weeks after his commitment. Stephen was not apprehended, and the case was carried by the agency seven months before he was released. It was believed but unconfirmed that he had been staying with relatives from time to time during this period. Reasons given for his release were: the agency's belief that he would be a serious school problem and behavior problem at Ormsby Village because he was so easily led; the agency doubted his mental

ability (borderline range) to control his delinquencies. He was recommitted eight months later on the charge of theft of a motor scooter. At the same time Stephen's mother was fined for contributing to his delinquency. Stephen was given a suspended sentence to Kentucky Houses of Reform on his recommitment. From the time he was placed at the Village he was either absent without leave or in the lock-up. His last unauthorized absence was two months long, when he was picked up on charges of stealing and wrecking a truck, carrying burglary tools, and cutting a screen door at an A&P store. His suspended sentence to Kentucky Houses of Reform went into effect and he was committed to that institution. There was very little opportunity for any service to be offered by the agency to this boy.

Broken Homes

The stability of the home has a great effect upon children and their behavior and happiness. Many children who are well physically find the emotional stress and strain of home conditions sometimes hard to bear. Children who have the further handicap of seizures have an additional disadvantage. It cannot be accurately measured how great a part this might play in the child's ability to accept his condition and adjust socially, but it is interesting to see how many children in the group came from broken homes. Table 6 is presented to show this in relation to the basis for commitment.

TABLE 6

CHILDREN FROM BROKEN HOMES
BY BASIS OF COMMITMENT

Reason for Commitment	Status of Home		
	Broken	Not Broken	Total
Dependency	16	1	17
Delinquency	6	5	11
Total	22	6	28

More than three-fourths, or 22 of the children came from broken homes. As to reason for commitment, 16 of the 22 from broken homes were committed for dependency and 6 for delinquency. Of the 6 who came from more stable homes, 1 was committed for dependency and 5 for delinquency.

Admissions to Children's Center

Since the Children's Center is used by the Louisville and Jefferson County Children's Home both before and after the children are committed to the agency as wards, it is interesting to see how many admissions each child had. Table 7 presents the findings on each of the 28 children.

The number of admissions for each child is shown before and after commitment. There is a further break-down as to dependency or delinquency. After a child has been committed to the Louisville and Jefferson County Children's Home either as a dependent or a delinquent, his subsequent admissions at the

TABLE 7

ADMISSIONS TO CHILDREN'S CENTER BEFORE AND AFTER COMMITMENT TO LOUISVILLE AND JEFFERSON COUNTY CHILDREN'S HOME

Admissions to Children's Center

Case	Before Commitment to L&JCCH			After Commitment to L&JCCH			Total Number
Number	Dep	Del	Total	Dep	Del	Total	Admissions
1	-	3	3	-	-	-	3
2	-	9	9	-	7	7	16
3	1	1	2	1	-	1	3
4	1	-	1	5	-	5	6
5	1	-	1	4	1	5	6
6	-	5	5	-	1	1	6
7	-	4	4	-	2	2	6
8	1	-	1	-	-	-	1
9	-	5	5	-	3	3	8
10	1	-	1	-	5	5	6
11	-	3	3	-	7	7	10
12	-	6	6	-	6	6	12
13	4	-	4	1	2	3	7
14	-	-	-	-	-	-	-
15	1	-	1	2	-	2	3
16	2	-	2	2	1	3	5
17	-	7	7	-	5	5	12
18	1	2	3	-	5	5	8
19	4	-	4	-	1	1	5
20	1	-	1	-	-	-	1
21	1	-	1	6	6	12	13
22	1	1	2	2	4	6	8
23	2	-	2	9	9	18	20
24	-	4	4	-	-	-	4
25	-	1	1	-	-	-	1
26	1	3	4	-	9	9	13
27	-	4	4	-	1	1	5
28	1	2	3	3	7	10	13
Total	24	60	84	35	82	117	201

L&JCCH - Louisville and Jefferson County Children's Home
Dep - Dependency
Del - Delinquency

Center carry the same designation, unless charges of the other designation have been filed against him. If the court changes his status from a dependent to a delinquent, or vica versa, his subsequent admissions then carry the new designation. This means, then, that a ward of the Louisville and Jefferson County Children's Home, committed as a dependent, would thereafter be admitted as a dependent at the Center from any number or unauthorized absences unless delinquent charges were filed against him by someone. By the same reasoning, if a child was committed to the agency as a delinquent and thereafter showed a great number of delinquent admissions to the Center, it would not necessarily mean that he was entered each time because he had done something or behaved in a delinquent manner, although it might mean that. He might be admitted for any of the reasons as previously stated, such as special treatment or study.[1]

Table 7 shows that 1 child, Case Number 14, was never known to the Children's Center. This was an unusual case, for seldom is a child committed to the agency without first going through the process of admission to the Center and all that goes with it. In the case of Ann, however, circumstances altered the usual procedure.

> Ann, the illegitimate child of a feeble-minded mother, had been under the supervision of a private children's agency since the age of three, placed first with the mother and a year later in a foster home. She was committed to the Louisville and Jefferson County Children's Home two years later at the request of the children's agency when she

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[1] Supra, p. 14.

was six. Since Ann had made such an excellent adjustment in the foster home, the children's agency offered to turn the home over to the Louisville and Jefferson County Children's Home as a foster home in order that Ann might remain in a home where she seemed happy and secure. These arrangements were made, which account for Ann's total lack of admissions to the Children's Center

As to the other children, it can be seen that all were known to the Children's Center before commitment. Although Table 7 does not reveal this, the writer observed in the study of the cases that a great many of the Center admissions following commitment were due to unauthorized absences.

No generalizations may be derived from this table as to the adjustment of the children. It is merely a portrayal of the number of times the child was known to the Center. It indicates, however, the variation between children and the fact that there must be underlying causes. The case of Russell, Case Number 23, who had a total of 20 admissions to the Center, is used as an illustration. When compared with Table 12[1], infra, this table has greater significance.

Russell, of dull normal ability, was committed as a dependent at the age of six with two older siblings. The mother was ill; the father worked and was unable to supervise. Three other older siblings had been previously committed. There were two younger siblings in the home. All were of borderline or dull normal intelligence.

Russell was considered the least attractive member of his family. He was frail and undernourished, and his left arm and shoulder were severely crippled as a result of infantile paralysis when six months old. His history bears

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[1] Infra, p. 61.

out rejection, neglect, and disinterest on the part of his family, especially the mother. The father died when Russell was ten. Russell was described as sullen, lazy, extremely dishonest, destructive, sneaking, vulgar and unclean in habits, and a severe behavior problem due to frequent unauthorized absences and stealing episodes.

This boy was a ward of the agency until the age of twelve. Within a two year period he had five foster home placements and one short placement at home. His second home placement at the age of eight lasted approximately one year, when he was returned to the Village for a period of three years until his final placement at home and the subsequent release within a month. Due to undernourishment and his frail condition Russell remained out of school the first year while in a foster home. There were other wards in the home but none of his siblings. Here he was the baby of the family and received a good deal of attention. He improved greatly in health and attitude but was still difficult to handle and inclined to be babyish. The foster mother requested his removal because he was not trustworthy and because of some stealing.

Russell was placed at home because his mother's health had improved. This placement lasted three months. He requested a foster home. About his own home he said: "I ain't got nothing." There were domestic difficulties, the mother became ill again, and Russell and an older sister were placed in another foster home. This foster mother found the children hard to manage and they were removed within three months.

The home situation was very bad during the one year period Russell was placed there. There were frequent absences and stealing. The standards were very low and none of the children was given any training or discipline. They were picked up by the police many times.

It was after his return to the Village that Russell was found to have an abnormal electroencephalogram and he was placed on medication. There was little or no improvement, however. He was seen by the psychiatrist and psychologist at various times. It was felt that he failed to respond to any kind of treatment. The cottage mother described him as a "dried up little old man," and he made a pathetic picture. He was confused and expressionless and showed very little responsiveness.

> After the father's death and when the mother was receiving pension money for the three younger children, she was not interested in Russell and the next two older children. She especially did not want Russell. He never heard from his mother or family when he was at the Village.

The above case illustrates a child whose many admissions to the Center were for the most part due to poor adjustment in various placements and to repeated and frequent unauthorized absences. Russell's status changed from a dependent to a delinquent after his arrest at home following an absence at the time of his father's funeral when he was involved in a stealing episode.

Siblings

There is no table to present the findings as to the siblings of the 28 children included in this study. Generally speaking, however, these children came from families with several children, for there were only 2 who had no siblings. One child's parents and family history were unknown. The remaining 25 children had siblings ranging in number from 1 to 8. Seven children had 2 siblings, 5 children had 3 siblings, 4 children had 5 siblings, and 4 had 6 siblings. Only 1 child had 8 siblings. The cases revealed both the characteristics of warm, close relationship between children as well as sibling rivalry.

History of Seizures in the Family

As far as is known, 8 of the 28 children had a history of seizures in some member of the family. Five of these 8

children had seizures also; the other 5 showed a predisposition to epilepsy and were considered behavior problems.

Classification of Medical Diagnoses

The diagnoses of the children were varied and did not fall readily into the three types of epilepsy as have been described previously.[1] Instead, the records often contained the term "idiopathic," which is synonymous with "true" or "essential" epilepsy. Lennox believes "essential" (or "idiopathic") is synonymous with "hereditary"; "symptomatic" epilepsy, on the other hand, is "acquired." Although many doctors believe the two groups are distinct, he feels that in most patients both hereditary (essential) and acquired (symptomatic) causes combine.[2]

The classification used by the writer in Table 8 seemed to be the most natural grouping according to medical diagnoses, since all children were not definitely diagnosed to have epilepsy. It was found that the children fell into four groups: (1) those with a diagnosis of epilepsy of whom some carried more than one diagnosis; (2) those diagnosed as borderline epilepsy; (3) those diagnosed as predisposition to epilepsy; and (4) those who had possible epileptic seizures which were never definitely diagnosed as epilepsy.

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[1] Supra, pp. 18-19.

[2] Lennox, Science and Seizures, pp. 41-42.

TABLE 8

CLASSIFICATION BY DIAGNOSIS OF CHILDREN WITH SEIZURES AND PREDISPOSITION TO EPILEPSY

Classification by Diagnosis	Number	Total
Epilepsy		
Encephalitis with Epilepsy, Epilepsy and Post-encephalitic Behavior Disorder	1	
Sub-clinical Epilepsy with Behavior Disorder	1	
Grand Mal	3[a]	
Petit Mal	1	
Idiopathic Epilepsy	1	
Primary Behavior Problem, Idiopathic Epilepsy	1	
Petit Mal, Grand Mal	1	
Total		9
Borderline Epilepsy		
Narcolepsy	1	
Borderline Epilepsy, Behavior Problem	1	
Total		2
Predisposition to Epilepsy	9	9
Possible Epileptic Seizures Never Diagnosed as Epilepsy	8	8
Total		28

[a]One child was released from the agency with a diagnosis of epilepsy with psychosis.

There were 9 children in the first group; 3 of them carried behavior disorder or problem as a part of the diagnosis of epilepsy or as an additional diagnosis. Three children had grand mal epilepsy, and 1 had grand mal in combination with petit mal. One child with grand mal was diagnosed upon release to have epilepsy with psychosis.

There were 2 children with borderline epilepsy. One had narcolepsy, which is characterized by attacks of sleeping. The second child was diagnosed to have borderline epilepsy and behavior problem.

Nine children were included in the third group, predisposition to epilepsy. These children all showed abnormal electroencephalograms. Without exception, they all made a poor social adjustment and had many problems during their period of commitment.

The fourth group included 8 children who had experienced seizures, some of which were at first thought to be epileptic but were never given a definite diagnosis of epilepsy. The case of Malcolm is an illustration.

> Malcolm, of average intelligence, was a ward of the agency for two years and was committed at the age of 13 as a delinquent for purse snatching. He had been in court on three previous filings involving stealing. He was the oldest of five children. There were two older half sisters in the home, children of the father's first marriage. Malcolm was his mother's favorite. He was jealous of his little sisters; he was never impudent to his mother. The father was a hard working shoe repair man, devoted to his family, who turned over all his income to the wife. She managed everything--the home, budget, children, etc. She was intelligent and a hard worker.

Following commitment Malcolm broke out of the Children's Center and was absent for over a month. He was returned when apprehended for destroying property. The mother worked out an approved plan to send Malcolm to a boarding school. He remained only two weeks and did not adjust too well. When his court record was learned, the school refused to keep him. He was again admitted to the Center when brought in on charges. He was placed at Ormsby Village where he remained for seven months.

His adjustment was good the first two months. He received psychiatric treatment, and progress seemed to be made. However, when plans for placement at home fell through due to the father's illness, Malcolm went completely to pieces. He was persistently absent for long periods of time. At his parents' request he was placed in a foster home, and arrangements were made to continue his psychiatric treatment on Saturdays at the Center. Malcolm failed to return to the foster home from most of these conferences, going instead to his own home and stating that he had been given permission not to return to the foster home. It was while he was in the foster home that the question of his having petit mal epilepsy came up, due to his sudden periods of "flattening" and restlessness. The matter of his stealing as an epileptic equivalent was also discussed in conference. His teacher found him able to do his work but his mind was "somewhere else." The electroencephalogram showed marked abnormality.

Two months after his foster home placement he was returned to the Center and from there placed at Ormsby Village, where he was to receive medication and treatment. He did not adjust at the cottage, was very belligerent, and took delight in upsetting people. He had nightly furor attacks which disturbed him and the group. He was considered obscene and even dangerous, when he threatened to kill another boy. He was thought emotionally incapable of understanding the consequences of his acts. He was placed on the Psychiatric Ward at Louisville General Hospital for one month for study and observation. Another electroencephalogram, after medication had been given, continued to show abnormality. Change in medication was recommended.

It was after this period of observation that the Social Service Department requested a definite diagnosis from the psychiatrist on Malcolm and four other children. The report follows: "I see no evidence for placing a label on them of a definite sort. . . . . there is behavior abrogation and . . . . there has been demonstrated some functional

disturbance, but to place this label on them[epilepsy]I feel would be a detriment to their long time treatment. I am very anxious to avoid any implications that this is true epilepsy."[1]

Upon his return to Ormsby Village, psychiatric treatment was continued as well as medication, and he was given a work assignment with special arrangements made for private tutoring in school work. There was some improvement, but he was disturbed because he could not quit school and go to work. His attitude was that since he had not been able to trust his family--plans for placement never materializing--he could not trust anyone. In any relationship he thought in terms of being "double crossed."

Malcolm was finally placed at home five months before his release. He was to continue to see the psychiatrist, and his mother gave consent for his taking medication, which she had not approved of earlier. He did well at home the first three months, and then he began staying out late and running with a gang of boys. He made threats to "kill all cops"; this embitterment toward police resulted from his blaming them for his first commitment. The mother sought the agency's help, admitting Malcolm's need for medication and offering to cooperate in seeing that he got it.

When he was apprehended by the police in a stolen car with loaded pistols he was sent to jail, where he admitted his difficulty. He was released to the Juvenile Court for disposition. Further psychiatric study was given over a period of three months. Although he was committed to Kentucky Houses of Reform, the psychiatrist believed there was definite progress made. Malcolm's attitude had changed. He seemed more able to face the results of his acts. There was some growth toward maturity, but whether or not he would use his more mature feelings in antisocial behavior or acceptable social growth was questioned.

The foregoing case history clearly illustrates the attitude of the psychiatrist toward the stigma of epilepsy. In other cases, there was evidence, also, of seeming reluctance of members of the medical profession to give a specific diagnosis

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[1] Statement by psychiatrist, from a case record, Louisville and Jefferson County Children's Home.

of epilepsy.. One child in the group who had seizures with no diagnosis of epilepsy was described as having "furor" attacks or epileptic equivalent, but the psychiatrist did not consider this epilepsy. Two children were treated as if for epilepsy and were referred to in the case record as having epilepsy, but there was no confirmation of this as a diagnosis. One boy had one grand mal-like convulsion; after receiving medication there was no known recurrence, and no definite diagnosis was given. Two children were considered behavior problems, although one had grand mal-like convulsions and the other had seizures resulting from brain damage from lead encephalitis. The last child in this group who had seizures was diagnosed as a behavior problem. Although his electroencephalogram was not too irregular, the interpretation of it stated that convulsive predisposition could not be ruled out.

Onset of Seizures and Behavior Problems

Yahraes states that 70 per cent of patients display their first symptoms before the age of 20. The peak age for the development of seizures is during the first two years of life, presumably because heredity and prenatal and birth injuries most likely show then. Another high point is during adolescence.[1]

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[1] Yahraes, op. cit., pp. 12-13.

Table 9 shows the relationship of the age of onset of seizures and behavior problems with the age of commitment. It can be seen that 16 of the 28 children were committed during the adolescent years from twelve on. Incidence of onset of seizures and behavior problems did not occur more frequently during the adolescent years, for only 8 children fell into this period. Four children had seizures within the first two years of life. Of the 28 children, the largest number, 4, had seizures or behavior problems at the age of eight.

It is interesting to note whether children were committed to the agency before or after the onset of seizures and behavior problems. Since the years shown are in even years with no months indicated, it was necessary to examine the individual cases where the figures coincided. In all the cases where it appears from Table 9 that the commitment age and the age of onset of seizures and behavior problems were the same, scrutiny of the records revealed that the child was committed after the age of onset of seizures and behavior problems. This is significant in that 22 of the 28 children were committed after the age of onset of seizures or behavior problems. In other words, the epileptic condition could easily have been an important and contributing factor in the commitment of the child and in the problems he presented. This was the case with these children.

TABLE 9

AGE OF ONSET OF SEIZURES AND BEHAVIOR PROBLEMS BY AGE AT COMMITMENT

Age of Onset of Seizures and Behavior Problems	Age at Commitment											
	6	7	8	9	10	11	12	13	14	15	16	Total
1	-	-	-	-	-	2	1	-	-	-	-	3
2	-	-	-	1	-	-	-	-	-	-	-	1
3	-	-	-	-	-	-	-	1	-	-	-	1
4	-	-	-	-	-	-	-	1	-	-	-	1
5	1	-	-	-	-	-	-	-	-	-	-	1
6	1	-	-	-	-	-	-	-	-	1	-	2
7	-	1	-	-	-	-	-	-	-	-	-	1
8	1	-	-	1	1	-	-	-	1	-	-	4
9	-	-	-	-	1	-	-	1	-	-	-	2
10	1	-	-	-	-	-	-	-	-	-	-	1
11	-	-	-	1	-	-	-	2	-	-	-	3
12	-	-	-	-	-	-	-	1	-	-	1	2
13	-	-	-	-	-	-	-	-	-	-	-	-
14	-	-	-	-	-	-	-	1	2	-	-	3
15	-	-	-	-	-	-	-	1	1	1	-	3
16	-	-	-	-	-	-	-	-	-	-	-	-
Total	4	1	-	3	2	2	1	8	4	2	1	28

Medication and Control by Medication

Although the most commonly used medications for epilepsy are phenobarbital, dilantin, and tridione, it was found that a great variation of medications was used for these children.

Table 10 shows the medications, singly and in combinations, used by the children at any one time.

TABLE 10

MEDICATION USED BY TWENTY-EIGHT CHILDREN AT ANY ONE TIME

Medication	No. of Children
Phenobarbital	11
Dilantin	10
Tridione	2
Phenobarbital and Dilantin	11
Phenobarbital and Tridione	1
Dilantin and Benzedrine	2
Tridione and Benzedrine	1
Phenobarbital, Dilantin, and Ascorbic Acid.	1
Phenobarbital, Dilantin, and Benzedrine.	1
Dilantin, Tridione, Benzedrine, and Sodium Bicarbinate	1
Dilantin, Benzedrine, and Sodium Bicarbinate.	1
Unknown	1

Eleven children used phenobarbital, 10 used dilantin, and only 2 used tridione. Phenobarbital and dilantin together were used by 11 children. The remaining combinations of medication would seem to show that the medical staff made every effort to place the child on the medication which would benefit him the most. This is seen more clearly in Table 11, which is a numerical listing of the number of different medications each child had.

Although Table 10 does not show this fact, there were 5 children who were taken off medication by doctor's orders at some time during their commitment.

Table 11 shows the number of different medications used by the children. Twenty-four of the 28 children were placed on medication. The remaining 4 never received medication,

TABLE 11

NUMBER OF DIFFERENT MEDICATIONS USED BY TWENTY-FOUR CHILDREN

Number of Different Medications	Number of Children
1	12
2	3
3	5
4	-
5	1
6	-
7	1
8	-
9	-
10	1
Unknown	1

although it was recommended for 1 child as a result of his electroencephalogram. However, the recommendation was not carried out as the doctor believed this boy would not benefit from it.

Of the 24 children who did receive medication, 12 used only one medication; 3 children used two different medications; 5 children used three different medications. There were 3 children who had their medications changed many times; 1 had five different medications; 1 had seven different medications; and 1 had ten different medications. In the case of 1 child the medication was unknown. This table significantly shows that there was considerable change in the use of medications in drug therapy. It would seem to indicate that a real attempt was made to control the child's seizures or improve his behavior from the medical angle.

Was the control by medication effective? As revealed by the case records, the following results were secured for the 24 children placed on medication: good control, 5 cases; fair control, 8 cases; poor control, 6 cases; still experimenting with medication, 2 cases; and unknown, 3 cases. The writer based this classification upon evidence as shown in the records. The diminishing of seizures and improvement in behavior were considered. Statements made by the physician, the psychiatrist, the cottage mother, the social worker, the teacher, the family--in fact, anyone who came in contact with the child--were noted and interpreted.

Only 5 children were considered as well controlled by medication. Eight children showed fair control; 1 of these included a boy whose seizures were controlled fairly well at Ormsby Village and poorly at home. One child whose control was unknown was not placed on medication until approximately one and one-half years after the medication was recommended. He had not been receiving medication for a period long enough to make an appraisal of the control.

CHAPTER IV

SOCIAL ADJUSTMENT OF THE GROUP

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SOCIAL ADJUSTMENT OF THE GROUP

The material presented in this chapter does not lend itself to tabular form as readily as that discussed in Chapter III. For the most part, the child's adjustment as shown by his attitudes and feelings, those of his family and others with whom he came in contact in the agency will be discussed.

Adjustment before Commitment to the Louisville and Jefferson County Children's Home

The problems presented by the 28 children before their commitment to the agency were many and varied. They ranged from a high incidence in such things as stealing, truancy from school, absence from home, enuresis, and inability to get along with other children to a low frequency in other problems. Some of the latter were as follows: laziness, excessive smoking, complaints by neighbors, pouting, refusing to eat and talk, wanderlust, shooting dice, pulling off all clothes, cursing, attacking and detaining little girls, lying, dishonesty, and spitefulness to mother.

The ways in which these problems were handled are revealing. Nine children were known to the Mental Hygiene Clinic, and 6 were known to the Louisville General Hospital

Department or Psychiatry. However, the majority or children had appeared in Juvenile Court numerous times as a result or antisocial behavior in the community. The Juvenile Court had placed 2 girls in Maryhurst and 1 boy in a Catholic orphanage; 1 girl was placed in the temporary custody or the Children's Agency. Two children were placed in private schools by their parents. At least 7 children received corporal punishment from their parents as a means or attempt to curb and control them.

Some of the many other ways parents handled their children's problems were: threaten and command, ridicule, over-protection and no restrictions, wash out mouth with lye, lock in the basement, force to eat, be overly strict, attack with a can opener, bribe with money, and send to the other parent where there was separation of the parents.

Except for seeking help from Louisville General Hospital Department of Psychiatry and the Mental Hygiene Clinic, none of these ways seemsvery constructive on the part of the parents.

Adjustment in the Institution and during Commitment to the Agency

The largest number of children met some of their needs by running away. Unauthorized absences were a problem of 24 of the 28 children. The matter of absences will be discussed more fully later and presented in tabular form.[1]

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[1] Infra, p. 60.

The following are some of the other frequent problems and attitudes of the children during commitment: aggression, attention getting, withdrawal, worry, shame, resentment, feels different, uses spells, enuresis, blames others, impudence, insecurity, lying, stealing, vulgarity, dirty clothes and habits, inferiority feelings, tattling, feels persecuted, feels rejected, sullen, nervousness, meddling, quiet, brooding and moody, disobedience, stubbornness, fussy and quarrelsome, bully and domineering, profanity, easily offended, lazy, argumentative, teases and provokes teasing, easily led, does foolish things, carries a "chip," sensitive, tearful, resents authority, homosexual tendencies, masturbation, overt sex behavior, impulsiveness, never satisfied, accepts no responsibility, and many others. Some of the aggression was shown by acts such as temper tantrums, destructiveness, hitting and fighting, as well as by aggressive attitudes.

The above shows that the problems of the children were many.

To return to the problem of unauthorized absences, distribution of which is presented in Table 12, it is noted that only 4 children did not run away during their commitment. The remaining children had unauthorized absences ranging in number from 1 to 22, with one child having an unknown number. The latter had 3 known unauthorized absences from Ormsby Village and an innumerable and unknown number from the foster home and his own home. Twenty children had 5 absences or less;

TABLE 12

DISTRIBUTION OF UNAUTHORIZED ABSENCES BY TWENTY-EIGHT CHILDREN

Number of Absences	Number of Children
0	4
1	4
2	1
3	4
4	3
5	4
6	1
7	1
8	-
9	1
10	1
11	-
12	-
13	1
14	-
15	1
16	-
17	-
18	-
19	-
20	-
21	-
22	1
Unknown	1

the remaining 8 children each had absences numbering over 6. The child with 22 unauthorized absences was Russell, who showed the largest number or Children's Center admissions, as presented in Table 7.[1]

One of the most interesting cases with reference to unauthorized absences was that of Harold, who ran away 13 times.

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[1] Supra, p. 41.

Harold was the middle of three boys. He lived in a "world of his own" and had made a poor social adjustment; the siblings were outgoing. He was committed at the age of 13 and released three years later when he was committed to Central State Hospital. He was diagnosed to have primary behavior problem and idiopathic epilepsy. His level of intelligence was low average. His seizures had begun at the age of 11 and prior to commitment he had been having three or four attacks a month. The father was hospitalized for cancer of the stomach at the time of Harold's commitment and died shortly thereafter. Harold was known to Mental Hygiene Clinic before his commitment to the agency.

Harold was committed as a delinquent for accosting and detaining little girls. The mother, a very nervous person, was very defensive and displayed an attitude of complete absorption of him. It was believed that Harold was fighting her domination, and his absences were looked upon by the psychiatrist as possible progress. On three of his absences he was apprehended in West Virginia; on several others he always went in that direction.

Harold was at Ormsby Village for one year before a change in status was made. During this time he had shown much improvement and was beginning to act like a normal boy with girls his age, no longer showing a flushed embarrassment. He had had no seizures for five months. After his older brother married, Harold felt he might also be able to break away from home and his mother's domination.

His placement at home was unsatisfactory and lasted only three months. His seizures began immediately upon his return home, which seemed to indicate the pressure was too great for him. His mother believed him "over-sexed" and thought an operation might help. When Harold was returned to the Center for detaining a little girl, the mother denied the possibility; she pretended ignorance of it when later confronted by witnesses.

Harold then remained at the Village for fourteen months until he was hospitalized for an eye injury. This period at Ormsby Village was characterized by more unauthorized absences. There was no improvement in his condition, although he was on medication except during absences. After he was given a summer work assignment on the farm he improved gradually. He gained weight and had no seizures that were known. The mother visited but was not quite as absorbing due to a sick daughter-in-law and new grandchild who had moved into the home while the older son was away in service.

The mother requested Harold's placement at home again but the Board deferred this for two months. References thought it dangerous for him to be in the community due to his repeated offenses with girls.

Arrangements were made for Harold to be placed at home after his hospitalization. This was not a satisfactory adjustment. His mother was over-protective and anxious. Harold felt she would not let him "grow up." They had frequent clashes. He could not accept the fact that he could not have as much freedom in his activities as his younger brother. He felt he was being punished by limitation of activity, necessary because of his seizures; this he resented very much. His seizures became more frequent followed often by periods of extreme irritability and violence. On two occasions in less than two months it was necessary to bring him to the Center because in a fit of violence he cut his brother, struck his sister-in-law, and tore the telephone from the wall. He made serious threats as to the use of a gun if he could obtain one.

The mother had a difficult time trying to face reality with regard to what was best for Harold and her responsibility for him in connection with the safety of others. She tried to place the responsibility either with the agency or the doctors. However, she finally made a voluntary filing on Harold for his commitment to Central State Hospital. Although the work done by the agency with Harold and his family did not seem to have terminated in success, it was believed that both he and his mother gained a better understanding of each other and were better able to face the future than before.

It should be pointed out that some children with only 2 or 3 unauthorized absences were gone for periods of 3 to 9 months, while others left and were returned the same day or shortly thereafter. Some children even returned themselves. Some children seemed almost glad when they were found at a place where one might expect them to be; it sometimes appeared as if they wanted to be brought back but could not take the step alone.

From a careful study of the records it seemed that no two cases were the same. Unauthorized absences were a problem

with many of the children. In all cases there was a reason for them, although the child was often unaware of what the emotional need was and how the absence met this need.

Attitudes of the Family

One of the most significant impressions gained from the study was the prominence of rejection by the family, especially by the mother. Rejection was seen in 22 of the 28 cases studied. Many of these children were not rejected due to epilepsy per se; rather, the whole child was rejected. On the other hand, it is hard to draw a line and say where or how much is due to the epilepsy which colors the personality of the child as a whole. There were cases where it could be clearly seen that the seizures were the basis for the rejection.

The fact that the child had seizures caused some parents to over-protect the child. Over-protection was seen in the cases of 8 children. In the cases of 9 children the parents exhibited worry. Eight children's families were helpful; the family attitudes of 6 children were shame for his seizures; and 6 families displayed misunderstanding and ignorance of his condition. Six children had no interest at all shown in them as revealed by no visits or contacts from the family. The parents of 3 children were fearful. Three families thought their child different, and 3 were over-indulgent.

Some of the other feelings and attitudes shown by the families were as follows: resentment, dislike, neglect, non-acceptance, defensiveness, blame of one parent by the other for the child's condition, over-criticism, belief that the child was feeble-minded when he was not, and unwillingness to take responsibility. On the positive side there were a few, but very few, instances of acceptance, interest, concern, and intelligent understanding shown by the families.

It can be seen, then, that generally speaking the child as a whole was not accepted, understood, helped with his problems or encouraged in arriving at a socially acceptable and satisfactory adjustment to life.

Attitudes Shown by Others in the Agency

It was not possible to secure specific figures for this phase in the child's adjustment during his commitment to the agency. However, some general impressions as revealed by the case records are felt to be of importance, since the way people feel toward each other is one indication of their adjustment.

The attitudes of the cottage mother toward the child seemed to indicate a selection by the agency of well-qualified personnel for this very important role. In nearly every case, the cottage mother showed liking, sympathy, interest, patience, and helpfulness toward the child. There were a few isolated

cases where dislike, disinterest, and impatience were thought to be shown. Some cottage mothers feared the child when violent, but surprisingly enough, many did not react in this way although they felt the child should be removed for the safety of the other children.

The most commonly noted attitudes shown by other children in the institution toward the child were some of the following: dislike, fear, unkindness, teasing, avoidance, non-acceptance, and "think he's crazy."

For the most part the teachers at the institution showed sympathy, interest, patience, and understanding. It was not possible to secure very much information on the attitudes of teachers who had contact with the child while he was placed off the campus. Some of the outstanding instances, however, were attitudes of misunderstanding, impatience, and non-acceptance, even when interpretation was given by the social worker. There were also positive evidences of patience, understanding, sympathy, and interest.

The social workers showed interest, sympathy, patience, understanding and acceptance for these handicapped children. The writer recalls only one case wherein the social worker repeatedly referred to the child's low mentality in spite of psychological tests to the contrary.

Foster mothers were often very patient with the child and showed kindness, sympathy, interest, and warm affection;

however, there was often a lack of understanding of the child's condition and his problems. Most of the foster mothers could not cope with stealing, and many did not have the patience to accept behavior problems that were repeatedly evident and which failed to clear up.

It is interesting to see how the child and his problems were handled by the agency and while in the institution. Twenty-four of the 28 children were known to have been placed in the lockup. Twenty-four children received care with medication to control their seizures and behavior. Eighteen children received psychiatric service from the Psychiatric Department of the agency, while 7 children were rererred to the Louisville General Hospital Department of Psychiatry. Four children were separated from others in the institution and placed in isolation. Corporal punishment was resorted to in a few cases; there were quite a few children who were given reprimands. However, the usual method of discipline and control while at the institution was through the operation of the citizenship system--earning a higher rank and enjoying the privileges incident to it when eligibility was established, and receiving reduced citizenship and its accompanying deprivations when that was indicated. Ordinarily, the children at Ormsby Village have a high regard for their citizenship status.

With all children, whether at the institution, in a foster home, or in their own home, case work service from a social worker was given throughout the entire period of commitment. In many cases there was a very good relationship between the child and his worker. This was not always as apparent in the cases in which there was frequent change of workers.

Psychiatric Referrals

The extent to which psychotherapy was used with the group of children is shown in a tabular analysis.[1] This was prepared to show rererrals to such service before and after commitment to the agency. The resources used were the Mental Hygiene Clinic, Louisville General Hospital Department of Psychiatry, and the Louisville and Jefferson County Children's Home psychiatrist. Each case is listed with the type of rererral, if any, indicated.

The analysis shows that 13 children received psychiatric service from one or more of the three resources before commitment and 20 children received psychiatric service after commitment. There is no comparison on the length of time covered and intensity of service before and after commitment.

Before commitment, 10 of the 13 children who received psychiatric service were known to the Mental Hygiene Clinic, while 6 children were known to the Louisville General Hospital

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[1] See Appendix D, p. 87.

Department of Psychiatry. Only 1 child was seen by the agency psychiatrist.

Following commitment, more children were seen by the Louisville and Jefferson County Children's Home psychiatrist than by the Mental Hygiene Clinic and Louisville General Hospital Department of Psychiatry together. Of the 20 children who received psychiatric service after becoming wards of the agency, 18 were seen by the agency psychiatrist, 7 were known to Louisville General Hospital Department of Psychiatry, and only 1 was referred to the Mental Hygiene Clinic.

This analysis shows that 5 of the 28 children received no psychiatric service at all during the time preceding their commitment and during their commitment.

It would seem, then, that a mental hygiene program of assistance for these children with their problems has played an important part in their adjustment. There were no norms by which to measure success or failure. The writer received the impression, however, that there was some progress in a considerable number of cases. Even in cases where the child went on to further antisocial behavior, as in the case of Harold,[1] the agency psychiatrist thought there had been improvement and some progress indicated.

Children Known to Other Institutions

Table 13 shows the number of children who were known to institutions before their commitment to the Louisville and

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[1] Supra, pp. 62-63.

TABLE 13

CHILDREN KNOWN TO OTHER INSTITUTIONS BEFORE AND AFTER COMMITMENT TO LOUISVILLE AND JEFFERSON COUNTY CHILDREN'S HOME

Institutions	Before Commitment	After Commitment
Kentucky Children's Home	2	-
St. Joseph's Orphanage	1	-
St. Thomas Orphanage	1	-
Maryhurst	2	-
Central State Hospital	1	4
Kentucky Houses of Reform	-	4
Kentucky Training School	-	1
Bellefair School (Cincinnati, Ohio)	1	-
Stuart Robinson School (Blakey, Kentucky)	-	1
Total	8	10

Jefferson County Children's Home as well as the number known to institutions after their commitment to the agency. From this presentation it can be seen that the commitment to Louisville and Jefferson County Children's Home was not the first institutional experience for 8 of the 28 children. The question may be raised as to the social adjustment made by these children in their first institutional setting. Without exception, the records revealed that all 8 had made an unsatisfactory social adjustment in the previous institution.

Ten children were known to other institutions following their commitment to the agency. The figures shown in Table 13, however, cover 15 different children. In other words, 3 children were known to two other institutions and 12

children were known to one other institution. The types of institutions which knew these children are revealed by the names of the institutions. The last two named are private boarding schools.

Eight of the 10 children known to other institutions after their commitment to the Louisville and Jefferson County Children's Home were known to Central State Hospital and Kentucky Houses of Reform. One child was known to Kentucky Training School. At this point, it should be mentioned that another child was committed to the Kentucky Training School, but due to crowded conditions she has never been entered there. She is still a ward of the Louisville and Jefferson County Children's Home and is not included in figures in Table 13.

Disposition upon Release from the Louisville and Jefferson County Children's Home

Fourteen of the 28 children were released from the supervision of the agency at the time of the study. It is interesting to see the immediate disposition upon release of these 14 children. This is shown in Table 14.

The child who was released to the Juvenile Court with a recommendation of commitment to the Kentucky Houses of Reform was subsequently committed there by the court. One child released to his parents, or Home, was later committed by the Juvenile Court to the Kentucky Houses of Reform.

The 2 children whose disposition was "Other" were released following the receipt of pertinent information regarding

TABLE 14

DISPOSITION OF FOURTEEN CHILDREN UPON RELEASE FROM THE LOUISVILLE AND JEFFERSON COUNTY CHILDREN'S HOME

Disposition upon Release	Number Released
Central State Hospital	4
Kentucky Houses of Reform	2
Kentucky Training School	1
Home	4
Juvenile Court	1[a]
Other	2[b]

[a]Released to Juvenile Court with a recommendation of commitment to Kentucky Houses of Reform.

[b]One child was killed while absent from home, thus released. The second child had been absent six months; following receipt of an unconfirmed report that he was working outside Jefferson County and living with his foster mother, he was released.

them after prolonged unauthorized absences. One child had been absent from home for four months; no word was received by the agency or his family until they learned of his death in an automobile accident in a southwestern state. The second child had been absent from Ridgewood for six months. Following receipt of an unconfirmed report that he was working outside Jefferson County and living with the foster mother who had reared him, he was released by the agency.

The number of children released to Central State Hospital seems significant. The 4 children who were committed there carried a diagnosis of epilepsy; 3 of them had "behavior disorder" as a part of their diagnosis; the other 1 was released with a diagnosis of epilepsy with psychosis. It

appeared that these children were unable to adjust in the community and in the institution. Since it was not considered safe for the other children at the Village to be subjected to their acts, they were sent to an institution for the mentally ill as a last resort. There was no other resource available for them in the state. Inquiry was made by the social worker about the possibility of admitting 1 child, David, to the Indiana Village for Epileptics. It was not possible, however, for the State of Indiana to admit a child from the State of Kentucky.

One of the 4 children released to the home was later committed by the Juvenile Court to the Kentucky Houses of Reform.

CHAPTER V

SUMMARY AND CONCLUSIONS

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SUMMARY AND CONCLUSIONS

Summary

The purpose of the study was to understand the social adjustment of epileptic children and those with a predisposition to convulsions in the Louisville and Jefferson County Children's Home. Analysis was made of the characteristics of the group and how they adjusted--what their problems were before commitment and how they were handled, what their problems were after commitment to the agency and how these were met, and the disposition upon release from the agency.

The group included 28 children, of which 23 were males and 5 were females; 22 were white and 6 were negro; 16 were committed for dependency and 12 for delinquency; 22 came from broken homes. The majority were committed during adolescence.

As to level of intelligence, 1 child was of superior intelligence, 10 were average, 9 were dull normal, 6 were borderline, and 2 were mentally defective. This distribution was similar to that of the Louisville and Jefferson County Children's Home population. Psychological tests showed that they achieved on a par and below their ability. Nine were placed in school above this achievement; 5 were assigned to special classes; and 4 did not attend school. Children did

not attend school due to unauthorized absences and detention in the lock-up and the Children's Center in the greatest number of cases. The group had many admissions to the Children's Center, both before and after commitment to the agency, for reasons of unauthorized absence, transfer of placement, and study purposes, with absences leading.

The majority of the children had siblings in their families; 8 showed a history of seizures in other members of the family. Medical diagnoses were grouped into four classifications: epilepsy, borderline epilepsy, predisposition to epilepsy, and possible epileptic seizures which were never diagnosed as epilepsy. There seemed evidence of some reluctance on the part of the medical profession to give a definite diagnosis of epilepsy, due possibly to the stigma it carried.

Sixteen of the children were committed to the agency during the adolescent years. Four children had seizures during the first two years of life and 4 at the age of eight. Twenty-two of the children were committed after the onset of seizures and behavior problems.

The Medical Department prescribed the usual medications used for this condition. There was an attempt to secure the proper medication for each child by change of prescription when the situation warranted it. Twenty-four children received medication. There was good control of seizures and behavior in 5 cases, fair control in 8 cases, and poor control in 6 cases.

The most common problems of the children before commitment were stealing, truancy from school, absence from home, enuresis, and inability to get along with other children. The Juvenile Court handled many of these children, and some were placed in other institutions. Parents seemed ineffectual and unable to cope with the situation.

During commitment, the largest number of problems of the children were unauthorized absence, aggression, attention getting, withdrawal, shame, and resentment. All but 4 children had unauthorized absences. One child had as high as twenty-two absences. Some absences were of short duration, and some were several months long.

Rejection of the child by the family, especially on the part of the mother, was present in 22 cases. Also, overprotection, worry, misunderstanding, and non-acceptance were common. The attitudes of staff members of the institution and agency were helpful and understanding. They showed extreme patience, interest, and sympathy. The children in the institution, however, disliked and "picked on" the epileptics frequently.

The lock-up was frequently used as a "cooling off" place after unauthorized absences. Since this group had many unauthorized absences, they were often placed there. The status of the child in the institution was frequently reduced.

Every child had a social worker who kept contact with him during his entire period of commitment. Psychiatric

service was given in 20 cases after commitment. The agency psychiatrist worked with 18 of them. Seven of the children were referred to Louisville General Hospital Department of Psychiatry during their commitment and 1 to Mental Hygiene Clinic.

Fifteen of the children were known to other institutions, either before or after commitment; 3 of these were known to two other institutions, and 12 were known to one other institution.

Fourteen children in the group were released by the agency. One was released to the Juvenile Court with a recommendation of commitment to Kentucky Houses of Reform, which was effected. Four were released to Central State Hospital, 2 to Kentucky Houses of Reform, and 1 to Kentucky Training School. Four were released to their home. One of the latter was later committed by the Juvenile Court to the Kentucky Houses of Reform.

Conclusions

The study has pointed out that children with epileptic seizures and a predisposition to convulsions have many problems. Many were committed to the Louisville and Jefferson County Children's Home because there was no other place for them to go. After commitment, it was difficult to find foster homes for those with seizures and difficult personality problems. Those who had placements in their own homes often returned to an

environment fraught with the same stresses and strains which proved difficult before. The Louisville and Jefferson County Children's Home offered the children the best service which was available.

However, it would seem that these handicapped children need a specialized institution when institutional care has been indicated. The writer feels that an epileptic colony or psychiatric hospital for children would benefit this type of child because there he would be fully accepted by all without reservation due to the physical condition. Kentucky has nothing of this sort to offer the child who must be institutionalized.

More specifically, the study revealed a common symptom of running away from the reality situation. It would seem that some further exploration might be indicated in this area with the hope of resultant recommendations around the problem.

A well-rounded mental hygiene program is needed wherein the child as a whole is considered. Psychotherapy and case work service seem indicated. The child needs to be kept busy and to feel useful and happy. Occupational therapy and vocational training are important phases of any treatment and care program.

There is a great need for further education and publicity around epilepsy. Not only must the epileptic be educated as to his condition, but also the professional groups and the general population must be better informed in order to relieve the misunderstanding, shame, and stigma attached to it.

There is hope for a full and satisfying life for most epileptics if they can learn to accept their condition and its limitations and be accepted by their friends and associates. Groups, such as the Health and Welfare Council of the Louisville Community Chest, which are showing interest in the epileptic child, are a promising move in that direction.

APPENDIX

APPENDIX A

RESULTS OF INTER-AGENCY COMMITTEE QUESTIONNAIRE ON EPILEPTICS AS OF JULY 1, 1947

Health and Welfare Council, Louisville
Community Chest

Agency	Individual Cases
Aid to Dependent Families Division	9
American Red Cross	1
Children's Agency	3
Children's Hospital	-
Division of Public Assistance (State)	26
Family Service Organization	4
Goodwill Industries	1
Jefferson County Welfare Department	*
Jewish Vocational Service	-
Jewish Welfare Federation	-
Juvenile Court	3
Kentucky Children's Home	-
Kentucky Crippled Children's Commission	3
Kentucky State Employment Service	6
Louisville Baptist Orphans' Home	-
Louisville and Jefferson County Children's Home	13
Louisville and Jefferson County Health Department. Medical Social Service Department	** **
Louisville Public Schools	*
Mental Hygiene Clinic	-
Municipal Bureau of Social Service	7
Nichols General Hospital	12
St. Joseph's Orphans' Home	-
St. Thomas Orphanage	-
St. Vincent Orphanage	2
Sisters of the Good Shepherd	-
State Vocational Rehabilitation Department	8
Synodical Presbyterian Orphanage	*
Veterans Administration	5
Visiting Nurse Association	-

*Did not return questionnaire
**Gave figures for year 1946, not specific date

APPENDIX B

INSTITUTIONS SURVEYED FOR EPILEPTIC CHILDREN, DECEMBER, 1947

Central State Hospital

Christian Church Widows and Orphans Home

Good Shepherd Home for Colored Girls

Kentucky Children's Home

King's Daughters Home for Incurables

Louisville and Jefferson County Children's Home

Maryhurst School - Sisters of the Good Shepherd

Masonic Widows and Orphans Home and Infirmary

Our Lady's Home for Infants

Protestant Orphans Home

St. Joseph's Orphans Home

St. Thomas Orphanage

St. Vincent Orphanage

Spring Meadows (formerly Louisville Baptist Orphans Home)

Synodical Presbyterian Orphanage

Woodcock Hall

SCHEDULE

APPENDIX C

1. Unit No. ___ 2. Name _____ 3. Age (birth date) _____

4. Sex _____ 5. Color _____

6. a. Institution
   (1) _____
   (2) _____
   (3) _____
   (4) _____

   b. Dates
   (1) from _____ to _____
   (2) _____ _____
   (3) _____ _____
   (4) _____ _____

   c. Age at committment
   (1) _____
   (2) _____
   (3) _____
   (4) _____

7. Reason committed

a. (1) ___	Delinquency	(2) ___	Dependency	(3) ___	Broken Home	(4) ___	Other(specify)_____
b. (1) ___	"	(2) ___	"	(3) ___	"	(4) ___	" _____
c. (1) ___	"	(2) ___	"	(3) ___	"	(4) ___	" _____
d. (1) ___	"	(2) ___		(3) ___		(4) ___	_____

8. a. Onset seizures (date) _____ b. Age ___

9. a. Date diagnosis _____ b. Age ___

10. Type
    a. ___ Grand mal
    b. ___ Petit mal
    c. ___ Psychomotor
    d. ___ Focal
    e. ___ Combined (specify) _____
    f. ___ Predisposition to epilepsy
    g. ___ Other (specify) _____

11. Frequency _____

12. EEG Impression & date _____

13. Medication
    a. ___ Phenobarbital
    b. ___ Dilantin
    c. ___ Tridione
    d. ___ Phenobarb & dilantin
    e. ___ Phenobarb, dilantin & tridione
    f. ___ Pheno, dil, trid, benzidrene
    g. ___ Other(specify) _____
    h. ___ " _____
    i. ___ " _____

14. Control
    a. ___ Good b. ___ Fair c. ___ Still experimenting with dosage d. ___ Other _____

15. Regulation or treatment
    a. ___ Regular medical supervision
    b. ___ Frequent medical supervision
    c. ___ Sporadic medical supervision
    d. ___ No supervision present time
    e. ___ Unknown

16. a. Mental development
    (1) Level of intelligence _____
    (2) EQ _____

    b. School
    (1) Grade _____
    (2) Non-attendance _____
    (3) Reason _____

17. a. Behavior before institutionalized b. How handled

(1) _____ (1) _____
(2) _____ (2) _____
(3) _____ (3) _____
(4) _____ (4) _____

18. Adjustment to illness

a. Socio-economic problems

(1) __ Financial
(2) __ Vocational
(3) __ School
(4) __ Family relations: (a) __ mother-father
(b) __ parent-child
(c) __ siblings
(5) __ Other (specify) _____

b. Physical problems

(1) _____ (2) _____
(3) _____ (4) _____

c. Emotional problems

(1) Attitudes of child in institution

(a) __ acceptance (e) __ withdrawal (h) __ misunderstanding (l) __ worried
(b) __ resentment (f) __ dependency (i) __ aggression (m) __ other(spec)_____
(c) __ shame (g) __ attention getting (j) __ run away (n) __ "
(d) __ unashamed (k) __ feels different (o) __ " _____

(2) Attitudes of child's family

(a) __ acceptance (e) __ over protection (i) __ he's different (n) __ _____
(b) __ resentment (f) __ rejection (j) __ worry (o) __ _____
(c) __ shame (g) __ helpfulness (k) __ other(spec)___ (p) __ _____
(d) __ unashamed (h) __ misunderstanding & ignorance (l) __ " _____ (q) __ _____
(m) __ _____ (r) __ _____

(3) Attitudes shown by others in institution

	(a) Housemother	(b) Soc Wkr	(c) Chrn	(d) Tchr	(e) Other____	(f)_____	(g)_____
1)	like						
2)	dislike						
3)	sympathy						
4)	interest						
5)	dis "						
6)	fear						
7)	patience						
8)	impatience						
9)	friendly						
10)	motherly						
11)	_____						
12)	_____						
13)	_____						

(4) How handled in institution

(a) __ Lockup (g) __ Discharge (k) __ Medical care
(b) __ Sent LGR-DP (h) __ Kept busier, given more responsibility (l) __ Other(specify)_____
(c) __ Change environment (m) __ " _____
(d) __ Isolation (n) __ " _____
(e) __ Ignored (i) __ Reprimanded (o) __ "
(f) __ Sympathy (j) __ Interpretation (p) __ Punished

19. Interests of child

a. Vocational	(1)	(2)	(3)
b. Hobbies & Recreation	(1)	(2)	(3)
c. School	(1)	(2)	(3)
d. Institutional home life	(1)	(2)	(3)
e. Others	(1)	(2)	(3)
f. "	(1)	(2)	(3)
g. "	(1)	(2)	(3)

20. Referrals to hospital, psychiatrist, mental hygiene clinic, etc.

	a. Where	b. Their record #
(1)		
(2)		
(3)		
(4)		

	c. Dates	d. Reason	e. Results
(1)			
(2)			
(3)			
(4)			

21. Siblings and child's relationship thereto

22. Family History

a. Other members of family having seizures:
(1) __ Mother (2) __ Father (3) __ Brother (4) __ Sister (5) __ Other(spec)

b. Other pertinent facts

23. a. Discharge from institution __ b. Date ____ c. Where

d. Reason

24.

25.

26.

APPENDIX D

RESOURCES OF PSYCHIATRIC SERVICES USED BEFORE AND AFTER COMMITMENT

Case No.	Resources of Psychiatric Services Used								
	Before Commitment to L&JCCH				After Commitment to L&JCCH				
	MHC	LGH-DP	L&JCCH Psychiatrist	Tot	MHC	LGH-DP	L&JCCH Psychiatrist	Tot	Tot
1		x		x		x		x	x
2						x	x	x	x
3		x		x		x	x	x	x
4									
5							x	x	x
6	x			x			x	x	x
7	x			x					x
8	x	x		x		x	x	x	x
9	x			x					x
10									
11	x	x		x		x	x	x	x
12	x			x			x	x	x
13							x	x	x
14	x			x			x	x	x
15									
16									
17						x	x	x	x
18	x			x			x	x	x
19					x	x		x	x
20									
21							x	x	x
22		x		x					x
23							x	x	x
24	x	x	x	x			x	x	x
25	x			x			x	x	x
26							x	x	x
27							x	x	x
28							x	x	x
Total	10	6	1	13	1	7	18	20	23

MHC - Mental Hygiene Clinic
LGH-DP - Louisville General Hospital Department of Psychiatry
L&JCCH - Louisville and Jefferson County Children's Home

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